Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MAJEED MASIH SARDAR MASIH**	**Service Date**	**:13-Aug-2024**	**Network**	: Green
Card No	: **I017-029-116125749-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **MAJEED MASIH SARDAR MASIH**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **03-Jan-1966**				
Patient's Tel No	: **0505140326**				

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC: Pain in the left shoulder joint. Duration: 3days. No history of trauma. Patient is advised on the need for exercise Referred to physiotherapist **Duration:**

Vitals: Temp : 36.4 Bp :140 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: M25.512 - Pain in left shoulder,E11.9 - Type 2 diabetes mellitus without complications,I10 - Essential (primary) hypertension,E78.5 - Hyperlipidemia, unspecified,Z79.899 - Other long term (current) drug therapy, **Date of Onset** :13/57/2024

Requested Investigations: 9, Consultation GP,9, Consultation GP,9, Consultation GP **Estimated Cost :**

Prescriptions: 0426-160701-2541 - (METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY,0027-142201-2401 - (DICLOFENAC POTASSIUM : 50 MG) SUGAR COATED TABLETS,0252-186702-0391 - (LOSARTAN POTASSIUM : 50 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS,2138-386002-0391 - (ATORVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS,0090-204901-0391 - (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 1000 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

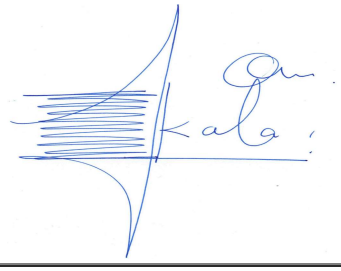
PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :  **Date :** 13-Aug-2024

Signature :  **Date** : 13-Aug-2024